

DEPARTMENT OF HEALTH

The Director, Radiation Control, Private Bag X62, BELLVILLE, 7535. ☎ (021) 9486162; Fax no. (021) 9461589
 The Assistant Director, Radiation Control, PO Box 977, PRETORIA, 0001, ☎(012) 3416322, Fax no (012) 3411651
 The Assistant Director, Radiation Control, PO Box 4301, DURBAN, 4000, ☎(031) 3072111, Fax no (031) 3076099

APPLICATION FOR A LICENCE IN TERMS OF ARTICLE 4(1)(b) AND 4(1)(c) OF THE HAZARDOUS SUBSTANCES ACT, 1973 (Act 15 of 1973) TO USE A THERAPEUTIC DEVICE OR PARTICLE ACCELERATOR

For office use only	
File no:	Licence no:

1. PARTICULARS OF APPLICANT

Name and postal address of individual or organisation:			
			Postcode:
☎		Fax no.:	
Email:		Cell no.	
Do you have any other licence(s)?	Yes	No	If yes, state one of them.

2. RESPONSIBLE PERSON

Surname:		Initials:		ID no:	
Address:					
Experience regarding radiation protection:					
Designation:			Qualification:		
☎		Fax no.:			
Email:		Cell no			
I am aware of my duties:	Signature:			Date:	

3. APPOINTED MEDICAL PHYSICIST (Only for radiotherapy)

Full time	Part time
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Surname:		Initials:		ID no:	
Address:					
HPCSA reg.			Qualifications:		
☎		Email:			
Fax no:		Cell no:			
I am aware of my duties:	Signature:			Date:	

4. IDENTIFICATION OF PRODUCT

Name of manufacturer:	
Brandname:	Year of manufacture:
Model:	Unit serial no:

5. OPERATIONAL FACTORS

Primary particles accelerated:	Electrons		Protons		
Type of radiation treatment:	Electrons	Photons	Neutrons	Protons	Other
State all the energies:	MeV				
	kV/MV				
Maximum current:	μ A/mA				

6. GENERIC DESCRIPTION

State the generic code of the product as found on the attached list (see page 3):

7. ACTIVITIES ENVISAGED

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.....
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8. PARTICULARS OF PREMISES


Building	Other:		
Address: - General (i.e. block, floor, room)			
Building:		Street:	
Section:			
Suburb:			Postcode:

9. INSTALLATION


Please attach a diagram or plan indicating the appropriate enclosure or room with special reference to:

- The normal location of the wave-guide; the direction and extent of gantry movement; general direction(s) of the useful beam; locations of any windows and doors; and the location of the control panel.
- The structural composition and thickness or lead equivalent of all walls, doors, partitions, floor, and ceiling of the room(s) concerned.
- The dimensions of the room(s) concerned.
- The type of occupancy of all adjacent areas inclusive of space above and below the room(s) concerned. If there is an exterior wall, show distance to the closest area(s) where it is likely that individuals may be present.

10. DETAIL OF PERSON/COMPANY FROM WHOM ELECTRONIC PRODUCT WAS OBTAINED (SUPPLIER)**10.1 New unit**

Name and postal address:	
	Licence number for Sale of this model:


10.2 Second-hand unit

Name and postal address:	
	User's licence number of previous owner:


State the reason if licence number is unavailable:

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11. DETAIL OF PERSON/COMPANY THAT WILL INSTALL THE ELECTRONIC PRODUCT (INSTALLER)

Name and postal address:	
	Fax no:

12. DETAIL OF PERSON/COMPANY THAT WILL MAINTAIN (SERVICE) THE ELECTRONIC PRODUCT(MAINTAINER)

Name and postal address:	
	Fax no:

13. DOSIMETRY SERVICE

Name of dosimetry service that will be made use of:

14. DECLARATION

I, (on behalf of) the applicant, (PLEASE PRINT):..... hereby declare that the information supplied is to the best of my knowledge true and correct.	
Signature:	Date:
Designation:	

For office use only	
Classification of user:	
Conditions:	
Comments:.....	
Inspected by:..... (code)	on:
Checked by:..... (code)	on:

Generic codes for therapeutic listed electronic products*Therapeutic electronic products*

Type of unit	Generic code
Open sector cyclotron	M141
Orthovoltage (kV) radiotherapy unit	M142
Linear electron accelerator	M143
Neutron therapy using a cyclotron	M144
Proton therapy using a cyclotron	M145
Solid pole cyclotron	M146